| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 04/26/16<br><br>Facility Number: 000369<br>Provider Number: 155530<br>AIM Number: 100275190<br><br>At this Life Safety Code survey, South Shore Health & Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br>This one story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. | K 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The facility has a capacity of 100 with a census of 68 at the time of the survey.<br>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage.<br><br>Quality Review completed on 05/02/16 - DA | | | |
| K 0018<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities.<br>19.3.6.3<br>1. Based on observation and interview, the facility failed to ensure 1 of 64 resident room corridor doors closed and latched into the door frame. This | K 0018 | ACTION TAKEN: Upon notification of finding,1)It was noted that the door backset on the door in room 312 was defective and was replaced on | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | deficient practice could affect 26 residents.<br><br>Findings include:<br><br>Based on observation and interview on 04/26/16 at 10:54 a.m., the Maintenance Director acknowledged the corridor door to resident room 312 failed to latch into the frame when tested.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 64 resident room corridor doors had no impediments to closing. This deficient practice could affect 26 residents.<br><br>Findings include:<br><br>Based on observation and interview on 04/26/16 at 11:55 a.m., the Maintenance Director acknowledged the corridor door to resident room 301 was obstructed by a bed in the way of the door.<br><br>3.1-19(b)<br><br>3. Based on observation and interview, the facility failed to ensure 1 of 1 400 Hall Linen Closet corridor doors latched into the door frame. This deficient practice could affect 16 residents. | | 04/26/16. 2) The bed was moved from 301A to 301B on 05/11/16. 3) Two passage knobs were placed that latch into the door frame on 05/03/16. 4)A Self closure with hold open was installed on 05/09/16 on both the Maintenance and conference room doors.All door stops removed. IDENTIFICATION OF OTHER RESIDENTS: The Maintenance Director did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: 1) There is a Maintenance request log book on each unit in the facility. 2) Observation of beds brought in by hospice for placement in room. 3) Resolved- No measures 4) All door stops removed. MONITORING OF CORRECTIVE ACTION: 1)The Maintenance Director and Maintenance Assistant will audit weekly x 2 months and monthly x 2 months the resident's door for proper latching with the " Resident door latch " audit form. All staff will be in-serviced by 05/20/16 on the maintenance request log book. 2) Staff will observe for extended bed brought in by Hospice that the resident is not in the first bed A (closest to the door). 3) No further action needed repaired. 4)All Staff will be inserviced by 05/20/16 regarding not using door stops.The Maintenance Director and Maintenance Assistant will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Findings include:<br><br>Based on observation and interview on 04/26/16 at 12:01 p.m., the Maintenance Director acknowledged the corridor door to the 400 Hall Linen Closet did not contain positively latching hardware.<br><br>3.1-19(b)<br><br>4. Based on observation and interview, the facility failed to ensure 1 of 1 Maintenance Office and 1 of 1 Conference room corridor doors had no impediments to closing. This deficient practice could affect staff and at least 10 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 10:00 then again at 10:39 a.m., the Maintenance office contained a wooden door stop. Then again, the Conference room contained a wooden door stop. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.<br><br>3.1-19(b) | | audit daily x4 week then weekly monthly x 2 months the resident's door for door stops usage with the " Door stop usage" audit form. Findings will be reviewed by the QA committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 0020<br>SS=D<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1<br>Based on observation and interview, the facility failed to ensure 1 of 1 vertical openings was enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.10 requires elevators open on more than one story at a time shall be provided with closing devices in accordance with 7.2.1.8. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 11:10 a.m., the freight elevator shaft had opening doors in the basement and 1st floor. In addition, the elevator shaft has an access panel in a Kitchen storage room. The access panel failed to self-close when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. | K 0020 | ACTION TAKEN: Upon notification of finding the access panel door was noted to not self close. After speaking to numerous people at the State and with assistance from Otis Elevator Services, it was determined that a self closure aircheck be installed on the access panel door on 05/18/16. IDENTIFICATION OF OTHER RESIDENTS: The Maintenance Director and Administrator did a further audit/ inspection of the other staff or resident's in the facility on 05/18/16 and no other staff or residents were found at risk. MEASURE IN PLACE: Self Closure installed and Life Safety code regulations. MONITORING OF CORRECTIVE ACTION: The Maintenance Director and Maintenance Assistant will audit daily x4 week then weekly monthly x 2 months the access panel door for self closure along with inspections per regulations by Otis Elevator Services. . Findings will be reviewed by the QA committee. | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3.1-19(b) | | | |
| K 0021 SS=D Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:<br>(a) The required manual fire alarm system and<br>(b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and<br>(c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2<br><br>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1<br><br>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.<br>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Laundry room, a hazardous area, would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at | K 0021 | ACTION TAKEN: Upon notification of finding the door stop was removed. A self closure with hold open was installed on 05/09/16. IDENTIFICATION OF OTHER RESIDENTS: The Maintenance Director did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: All door stops removed, hold open installed. MONITORING OF CORRECTIVE ACTION: All Staff will be | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 11:30 a.m., the Laundry room contained fuel fired appliances. The corridor door in the Laundry room had a wooden wedge preventing the door from self-closing and positively latching into the frame. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | | inserviced by 05/20/16 regarding not using door stops.The Maintenance Director and Maintenance Assistant will audit daily x4 week then weekly monthly x 2 months the resident's door for door stops usage with the " Door stop usage" audit form. Findings will be reviewed by the QA committee. | |
| K 0025 SS=D Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.<br>8.3, 19.3.7.3, 19.3.7.5<br>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observations with the Maintenance Director on 04/26/16 at | K 0025 | ACTION TAKEN: Upon notification of finding the the gap in the ceiling tile, the tile was removed and replaced. The Conduit gap was sealed on 04/28/16. IDENTIFICATION OF OTHER RESIDENTS: The Maintenance Director did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: Any construction areas will be assessed after any work by outside vendors are completed for any breaches. MONITORING OF CORRECTIVE ACTION: The | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 10:08 a.m., the 500 Hall Janitors Closet contained two separate conduit tubes going through ceiling. The space inside the quarter inch conduit tube was unsealed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | | Maintenance Director and/or Maintenance Assistant will inspect all construction or repairs involving any ceiling tile after completion of work for any penetrations and or breaches. Findings will be reviewed by the QA committee. | |
| K 0029<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Food Storage Room greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and at least 19 residents.<br><br>Findings include: | K 0029 | ACTION TAKEN: Upon notification of finding 1) On 05/10/16 The air check was modified and the door now self latches. 2)The vegetable popcorn oil was a removed. A coconut popping oil ( non-vegetable or animal base) was order 05/11/2016. 3)A Air check was installed 05/17/16 and a keypad autolock was 05/19/16. IDENTIFICATION OF OTHER RESIDENTS: The Maintenance Director did a further audit/ | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Based on observation with the Maintenance Director on 04/26/16 at 10:19 a.m., the Food Storage room contained a wooden pallet with about fifty cardboard boxes. The corridor door failed to self-close and latch when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b)<br>2. Based on observation and interview, the facility failed to ensure 1 of 2 hazardous cooking areas was separated from the corridor by smoke resistive partitions or doors. This deficient practice could affect up to 12 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 11:40 a.m., a mobile popcorn popper was in the Dining Room. The dining room does not have a full smoke resistive partition from the corridor. Based on interview at the time of observation, the Maintenance Director acknowledged that vegetable oil is used to cook the popcorn and was being operated in the Dining Room.<br><br>3.1-19(b) | | inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: 1)All door assessed for self closure as needed.-resolved 2) Non vegetable or animal base oils used. 3)All door assessed for self closure as needed. -resolved MONITORING OF CORRECTIVE ACTION: 1)The Maintenance Director and Maintenance Assistant will audit weekly x 2 months and monthly x 2 months the resident's door for proper latching with the " Resident door latch " audit form. 2) the popcorn oil was a removed. A coconut oil popping base was order 05/11/2016.-resolved. Activities staff in serviced on 05/12/16 3) The Maintenance Director and Maintenance Assistant will audit weekly x 2 months and monthly x 2 months the resident's door for proper latching with the " Resident door latch " audit form. Findings will be reviewed by the QA committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 200 Hall Tub room containing more than 32 gallons of soiled linen, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and at least 4 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 11:27 a.m., the 200 Hall Tub room contained two separate thirty gallon containers of soiled linens. The corridor door failed to self-close and latch when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | | | |
| K 0046<br>SS=F<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.<br>18.2.9.1, 19.2.9.1.<br>Based on record review and interview; the facility failed to ensure 10 of 10 battery operated emergency lights in the | K 0046 | ACTION TAKEN: Upon notification of finding of deficiency, The Maintenance Director, Maintenance Assistant | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 9:24 a.m., the battery operated emergency light testing documentation contained checkmarks under each month. Based on interview at the time of observation, the Maintenance Director explained the emergency lights were tested with a quick press of the test button and not for thirty seconds.<br><br>3.1-19(b) | | was in- serviced on the Life safety code 7.9.3 on 05/11/16. Policy updated to include 30 second hold. IDENTIFICATION OF OTHER RESIDENT: The Maintenance Director and inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: Preventive Maintenance- Battery backup inspection report form done monthly. MONITORING OF CORRECTIVE ACTION: The Maintenance Director and Maintenance Assistant will audit monthly on going. Findings will be reviewed by the QA committee. | |
| K 0050<br>SS=C<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Fire drills include the transmission of a fire | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2<br>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents.<br><br>Findings include:<br><br>Based on record review of the "Fire Drill Report" forms with the Maintenance Director on 04/26/16 at 9:42 a.m., four sequential first shift fire drills took place between 9:25 a.m. and 11:05 a.m. for four of the last four quarters. Additionally, four sequential second shift fire drills took place between 7:17 p.m. and 9:10 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b)<br>3.1-51(c) | K 0050 | ACTION TAKEN: Upon notification of finding 1) It was noted that 4 quarters have not been established since the last Life Safety inspection on 10/13/15, in which the facility was cited. Since POC in November of 2015, the Maintenance director has conducted the fire drill in compliance with this code. 2) The monitoring company -Reliable was notified on 05/11/16 regarding giving a transmission time of signal on all future fire drills. the fire drill log was updated to reflect the "transmission time" on all future fire drills. IDENTIFICATION OF OTHER RESIDENTS: The The Maintenance Director did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: A audit of the fire drills will be conducted quarterly by the Administrator. MONITORING OF CORRECTIVE ACTION: .The Maintenance Director and /or | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants.<br><br>Findings include:<br><br>Based on record review of titled "Fire Drill Report" with the Maintenance Director on 04/26/16 at 9:42 a.m., the documentation for the drills failed to include verification of transmission of the fire alarm signal to the monitoring station. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b)<br>3.1-51(c) | | Maintenance Assistant will conduct the fire drills per code and the Administrator will review quarterly times 1 year for compliance. Findings will be reviewed by the QA committee. | |
| K 0056<br>SS=D<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Where required by section 19.1.6, Health | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13<br>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 Freight Elevator vertical shafts in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator hoistways shall be ordinary or intermediate temperature rating. This deficient practice could affect up to 4 residents.<br><br>Findings include:<br><br>Based on an observation with the Maintenance Director on 04/26/16 at 11:10 a.m., there was an elevator hoistway opening into the corridor. Based on interview at the time of observation, the Maintenance Director did not know if | K 0056 | ACTION TAKEN: Upon notification of finding Otis Elevator was contacted on 05/11/016 regarding finding. The sprinkler system in the shaft is schedule to be done by 05/26/16 by Valley Fire Protection Systems . IDENTIFICATION OF OTHER RESIDENTS: The Maintenance Director and Administrator did a further audit/ inspection of the other resident's in the facility on 04/27/16 and no other residents were found at risk. MEASURE IN PLACE: Resolved with installation with Inspections per regulations of Life Safety codes. MONITORING OF CORRECTIVE ACTION: Findings will be reviewed by the QA committee. | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | a sprinkler head was installed, if there were hydraulic lines in the elevator hoistway, or what the construction rating was of the elevator hoistway. | | | |
| K 0062<br>SS=F<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br>1. Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system wasmaintained in accordance with NFPA 25, 1998 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on or hung from the pipe. This deficient practice could affect all occupants if the sprinkler system had to be shut down for repairs.<br><br>Findings include:<br><br>Based on observations with the Maintenance Director on 04/26/16 at 11:17 a.m., a water pipe located in the Basement Mechanical Room was being supported from a piece of wire supported off of the sprinkler pipe. Then again, a light bulb in the Basement Mechanical | K 0062 | ACTION TAKEN: Upon notification of finding the a clamp was attached to the ceiling to support the water pipe. The light bulb base is moved on 05/11/16. 2) The escutcheon ring was replaced on 04/27/16. 3) The sprinkler heads are scheduled to be replaced by 05/26/16. 4) The boxes were removed upon finding. IDENTIFICATION OF OTHER RESIDENTS: The Maintenance Director, Maintenance Assistant and Administrator did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: Valley Fire continues to do inspections of the sprinkler system per regulations. MONITORING OF CORRECTIVE ACTION: Inspection by Valley Fire will continue along issue has been resolved. The Maintenance Director and/or Maintenance Assistance will review the reports for compliance in conjunction with | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Room was attached directly to the sprinkler pipe. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler head in Office Manager room was maintained. This deficient practice could affect staff and up to 19 residents.<br><br>Findings include:<br><br>Based on observations the Maintenance Director on 04/26/16 at 10:35 a.m., the Office Manager room was missing one escutcheon ring. Based on interview at the time of observation, the Maintenance Director acknowledged the missing escutcheon at the time of observation.<br><br>3.1-19(b)<br><br>3. Based on observation and interview, the facility failed to replace 3 of 3 400 Hall shower room corroded sprinkler heads. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the | | the regulated inspections ongoing. 4) The entire staff was inserviced on the 18"clearance rule. A room audit will be done daily by the Maintenance Director Maintenance Assistant or Environmental director daily x3 weeks then weekly x 2 months. Findings will be reviewed by the QA committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and up to 1 resident.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 10:48 a.m., three sprinkler heads were corroded in the 400 Hall shower room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b)<br><br>4. Based on observation and interview, the facility failed to ensure a clearance of at least 18 inches was maintained below the level of the sprinkler deflector for 1 of 1 400 Hall Storage Room. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, 1999 edition, at 5-5.5.1 says a continuous or noncontinuous obstruction less than or equal to 18 inches below the sprinkler deflector prevents the spray pattern from | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | fully developing. This deficient practice affects staff only.<br><br>Finding includes:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 12:07 p.m., five large cardboard boxes were stored five inches from the ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | | | |
| K 0064 SS=E Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10.<br>18.3.5.6, 19.3.5.6<br>Based on observation and interview, the facility failed to ensure 1 of 1 Mechanical Room, 1 of 2 300 Hall, and 1 of 3 Dining Room fire extinguisher pressure gauge readings were in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) | K 0064 | ACTION TAKEN: Upon notification of finding , Valley Fire was called and the fire extinguishers were replaced on 05/02/16. IDENTIFICATION OF OTHER RESIDENTS: The Life Safety Surveyor and The Maintenance Director did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: Continue inspections per regulations. MONITORING OF CORRECTIVE ACTION: Continue inspections of | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff and up to 5 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 between 10:39 a.m. and 11:00 a.m., the following fire extinguishers were undercharged:<br>a) Mechanical Room<br>b) Outside resident room 315<br>c) Outside the Kitchen<br>Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition.<br><br>3.1-19(b) | | extinguishers per regulations. Per The Valley Fire inspector, fluctuations in the temperature and humidity will cause the charge to fluctuate. The Maintenance director or Maintenance Assistant will audit weekly x2 months then monthly x 2 months with the " Fire extinguisher charge" audit form. Findings will be reviewed by the QA committee. | |
| K 0069 SS=C Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96<br>Based on record review and interview; the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the | K 0069 | ACTION TAKEN: Upon notification of finding a inspection was completed on 04/27/16. It was setup with Koorsen Fire and Security to have the inspections done routinely per code.<br>IDENTIFICATION OF OTHER RESIDENTS: The Life Safety Surveyor and The Maintenance Director did a further audit/ inspection of the other resident's | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on record review with the Maintenance Director on 04/26/16 at 12:55 p.m., the most recent range hood fire extinguishing equipment inspection report was dated 11/07/14. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | | in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: A auto schedule for inspection was setup with Koorsen for the facility's account for all future inspections. MONITORING OF CORRECTIVE ACTION: The Maintenance Director will keep a log of the inspections and the Administrator will review every 6 months ongoing for compliance. Findings will be reviewed by the QA committee. | |
| K 0070<br>SS=D<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | where the heating elements of such devices do not exceed 212 degrees F (100 degrees C).<br>18.7.8, 19.7.8<br>Based on observation, interview, and record review, the facility failed to enforce the policy for the use of 1 of 1 400 Hall Nurse's station medication room portable space heaters in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any number of staff.<br><br>Findings include:<br><br>Based on record review with the Maintenance Director on 04/26/16 between 9:08 a.m. and 10:00 a.m., the space heater policy states the facility does not allow space heaters. Based on observation, a space heater was discovered in the 400 Hall Nurse's station medication room. Based on interview at the time of observation, the Maintenance Director acknowledged the space heater were a violation of the facility's policy.<br><br>3.1-19(b) | K 0070 | ACTION TAKEN: Upon notification of finding the space heater in the medication room, it was not in use nor was it plugged in. IDENTIFICATION OF OTHER RESIDENTS: The Life Safety Surveyor and The Maintenance Director did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: Facility policy and Life Safety regulation. MONITORING OF CORRECTIVE ACTION: In accordance with Life safety code 18.7.8, " Portable space heaters shall be prohibited in all healthcare occupies , unless both of the following criteria are met. - Such device are permitted to be used only in non-sleeping staff and employee areas and the heating element of such device do not exceed 212* F. " As stated above, was in a permitted area and the element temperature does not exceed 212*. REASON FOR IDR: PER Life safety code and facility policy, the space heater/heating element was in compliance as stated above. | 05/26/2016 |
| K 0075<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5<br>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1 Resident Room 315. This deficient practice could affect staff and up to 26 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 10:52 a.m., Resident Room 315 was being used as isolation and contained two separate 30 gallon containers of soiled linen. The resident room door did not have a self closing device installed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | K 0075 | ACTION TAKEN: The containers in room 315 were replaced with 13 gallon containers on 05/12/2016. Also by placing a self closure on a resident's room would increase the risk of bodily injury regarding the ingress and egress of a sleeping room. IDENTIFICATION OF OTHER IDENTIFICATION OF OTHER RESIDENTS: The Maintenance Director and Administrator did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: Life safety code and CDC guidelines for isolation precautions. MONITORING OF CORRECTIVE ACTION: The Maintenance Director, Environmental Director and Director of Nurses was inserviced on 05/17/16 regarding isolation container requirements. Findings will be reviewed by the QA committee. | 05/26/2016 |
| K 0130 | NFPA 101 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| SS=E<br>Bldg. 01 | MISCELLANEOUS<br>OTHER LSC DEFICIENCY NOT ON 2786<br>Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:<br>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:<br>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.<br>b. It shall be protected by an approved device that is designed for the specific purpose.<br>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:<br>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. | K 0130 | ACTION TAKEN: Upon notification of finding the the gap in the cement brick was sealed with concrete on 04/28/16. IDENTIFICATION OF OTHER RESIDENTS: The Life Safety Surveyor and The Maintenance Director did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURE IN PLACE: Any construction areas will be sealed with either Fire Barrier 4 hr rated caulking or concrete if within the brick. MONITORING OF CORRECTIVE ACTION: The Maintenance Director and/or Maintenance Assistant will inspect all construction or repairs involving any fire barrier walls after completion of work for any penetrations and apply barrier repairs if warranted. Findings will be reviewed by the QA committee. | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | b. It shall be protected by an approved device that is designed for the specific purpose.<br>This deficient practice could affect staff and up to 16 residents.<br><br>Findings include:<br><br>Based on an observation with the Maintenance Director on 04/26/16 at 12:35 p.m., a three inch gap between cement bricks was unsealed above the ceiling tile in the fire barrier near Maintenance. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.<br><br>3.1-19(b) | | | |
| K 0147 SS=E Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Electrical wiring and equipment shall be in accordance with National Electrical Code.<br>9-1.2 (NFPA 99) 18.9.1, 19.9.1<br>1. Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for | K 0147 | Upon finding 1) -IDR-It was noted that the observation regarding the alleged findings was dated 07/20/2015 . Survey date was 04/26/16. This is a inaccurate finding. Action Taken: 2) The junction box on 200 hall was replaced on 05/12/2016. IDENTIFICATION OF OTHER RESIDENTS AT RISK: The Life Safety Surveyor and The | 05/26/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | fixed wiring of a structure. This deficient practice affects staff and up to 38 residents.<br><br>Findings include:<br><br>Based on observation with Maintenance Director on 07/20/15 between 10:17 a.m. to 11:42 a.m. the following was discovered:<br>a) a surge protector was powering a refrigerator in the MDS office<br>b) a surge protector was powering a refrigerator in the Office Manager office<br>c) a surge protector was powering two separate refrigerators in the 400 Hall nurse's station medication room<br>d) a surge protector was powering a refrigerator in the 200 Hall medication room<br>e) a surge protector was powering an air conditioner in the Hair Salon<br>Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 1 200 Hall fire barrier electrical junction box observed was maintained in a safe operating condition. LSC 19.5.1 requires | | Maintenance Director did a further audit/ inspection of the other resident's in the facility on 04/26/16 and no other residents were found at risk. MEASURES IN PLACE: 2)The Maintenance Director and/or Maintenance Assistant will inspect all construction or repairs after completion for compliance. CORRECTIVE ACTION IN PLACE: 2)The Maintenance Director and/or Maintenance Assistant will inspect all construction or repairs after completion for compliance. Any finding will be reviewed by the QA committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155530 | A. BUILDING 01<br>B. WING | 04/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect staff.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 04/26/16 at 12:40 p.m., there was exposed wiring in a junction box without a cover above the drop ceiling near the 200 Hall fire barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | | | |